		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0013896

Facility Name: St Matthew Center for Health

Address: 1601 N. Western Ave (Number) Park Ridge, Illinois (City) 60068 (Zip Code)

County: Cook

Telephone Number: (847) 825-5531 **Fax #** (847) 318 - 6659

IDPA ID Number: 36-2584799 - 001

Date of Initial License for Current Owners: 1959

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL		
	[X] Charitable Corp.		[ ] Individual		[ ] State		
	[ ] Trust		[ ] Partnership		[ ] County		
IRS Exemption Code	501 (C) (3)		[ ] Corporation		[ ] Other		
			[ ] "Sub-S" Corp.				
			[ ] Limited Liability Co.				
			[ ] Trust				
			[ ] Other				

In the event there are further questions about this report, please contact:
Name: Sonia Channa **Telephone Number:** (847) 390 - 1411

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/02 to 06/30/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Frederick Aigner
(Title) President

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/02 Ending: 06/30/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 176

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)	56	20,440	3
4		Intermediate/DD			4
5	56	Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	176	TOTALS	176	64,240	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		26,150	5,422	31,572	8
9	SNF/PED	11,886			11,886	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,886	26,150	5,422	43,458	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.65%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [N/A]

I. On what date did you start providing long term care at this location?
Date started 1959

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 5,422

Medicare Intermediary Adminastar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/03 Fiscal Year: 06/30/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/02 Ending: 06/30/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	294,613	28,264	100,450	423,327		423,327		423,327			1
2	Food Purchase		223,845		223,845		223,845	775	224,620			2
3	Housekeeping	110,194	65,932		176,126		176,126		176,126			3
4	Laundry	51,281	9,319	69,458	130,058		130,058		130,058			4
5	Heat and Other Utilities			173,222	173,222		173,222		173,222			5
6	Maintenance	135,839	8,031	98,935	242,805	1,891	244,696		244,696			6
7	Other (specify):* Rubish removal			16,511	16,511	782	17,293		17,293			7
8	**TOTAL General Services**	591,927	335,391	458,576	1,385,894	2,673	1,388,567	775	1,389,342			8
	B. Health Care and Programs											
9	Medical Director			14,500	14,500		14,500		14,500			9
10	Nursing and Medical Records	2,668,821	303,718	20,658	2,993,197		2,993,197		2,993,197			10
10a	Therapy	21,305		315,826	337,131		337,131		337,131			10a
11	Activities	36,735	2,475	3,622	42,832		42,832		42,832			11
12	Social Services	113,436		8,487	121,923		121,923		121,923			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Dentist			5,832	5,832		5,832		5,832			15
16	**TOTAL Health Care and Programs**	2,840,297	306,193	368,925	3,515,415		3,515,415		3,515,415			16
	C. General Administration											
17	Administrative	63,415			63,415	237,243	300,658		300,658			17
18	Directors Fees											18
19	Professional Services			596,229	596,229	(412,042)	184,187	675	184,862			19
20	Dues, Fees, Subscriptions & Promotions			17,700	17,700	34,424	52,124		52,124			20
21	Clerical & General Office Expenses	233,314	27,135	73,860	334,309	35,601	369,910		369,910			21
22	Employee Benefits & Payroll Taxes			846,673	846,673	47,614	894,287		894,287			22
23	Inservice Training & Education					1,813	1,813		1,813			23
24	Travel and Seminar			5,331	5,331		5,331		5,331			24
25	Other Admin. Staff Transportation					5,264	5,264		5,264			25
26	Insurance-Prop.Liab.Malpractice			13,685	13,685	9,187	22,872		22,872			26
27	Other (specify):* Fundraising					637	637	(10,615)	(9,978)			27
28	**TOTAL General Administration**	296,729	27,135	1,553,478	1,877,342	(40,259)	1,837,083	(9,940)	1,827,143			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,728,953	668,719	2,380,979	6,778,651	(37,586)	6,741,065	(9,165)	6,731,900			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number St Matthew Center for Health #0013896 Report Period Beginning: 07/01/02 Ending: 06/30/03

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			387,612	387,612	26,916	414,528	(1,957)	412,571			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			210,026	210,026	4,469	214,495	(23)	214,472			32
33	Real Estate Taxes					145	145		145			33
34	Rent-Facility & Grounds					544	544		544			34
35	Rent-Equipment & Vehicles			23,182	23,182	5,512	28,694		28,694			35
36	Other (specify):*											36
37	**TOTAL Ownership**			620,820	620,820	37,586	658,406	(1,980)	656,426			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			96,360	96,360		96,360		96,360			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			96,360	96,360		96,360		96,360			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,728,953	668,719	3,098,159	7,495,831		7,495,831	(11,145)	7,484,686			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/02 Ending: 06/30/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	775	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(241)	30		9
10	Interest and Other Investment Income	(23)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(10,615)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(438)	19,30,24		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (10,542)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	(603)	30	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (603)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (11,145)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

St Matthew Center for Health

ID# 0013896

Report Period Beginning: 07/01/02

Ending: 06/30/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Allowable Mgmt & HR Allocation	$ 390	19	1
2	Allowable Serv. Network Allocation	285	19	2
3	Management Auto Depreciation	(1,113)	30	3
4	Prior Fiscal Year Travel	0	24	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(438)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number St Matthew Center for Health # 0013896 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	775	0	0	0	0	0	0	0	0	0	0	775	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	775	0	0	0	0	0	0	0	0	0	0	775	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	675	0	0	0	0	0	0	0	0	0	0	675	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(10,615)	0	0	0	0	0	0	0	0	0	0	(10,615)	27
28	**TOTAL General Administration**	(9,940)	0	0	0	0	0	0	0	0	0	0	(9,940)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(9,165)	0	0	0	0	0	0	0	0	0	0	(9,165)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Matthew Center for Health # 0013896 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(1,957)	0	0	0	0	0	0	0	0	0	0	(1,957)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(23)	0	0	0	0	0	0	0	0	0	0	(23)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,980)	0	0	0	0	0	0	0	0	0	0	(1,980)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(11,145)	0	0	0	0	0	0	0	0	0	0	(11,145)	45

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A	N/A	N/A	N/A	Vesper Mgmt Corp	Des Plaines Illinois	Mgmt co.
				LSSI	Des Plaines Illinois	Corp. Office

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		N/A	$	N/A		$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lutheran Social Services of Illinois
Street Address: 1001 E. Touhy Ave. Ste 50
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (847) 635-4600
Fax Number: (847) 635-6764

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Non Capital Direct Costs	26,780,136	317	$ 1,460,744	$ 1,460,744	1,715,305	$ 93,563	1
2	22	Empl Benefits & Taxes		26,780,136	317	216,722		1,715,305	13,881	2
3	19	Prof Fees & Contract		26,780,136	317	2,351,431		1,715,305	150,612	3
4	21	Supplies, Telephone		26,780,136	317	378,596		1,715,305	24,250	4
5		Postage, Out. Printing		26,780,136	317	0		1,715,305	0	5
6	34	Rental of Space		26,780,136	317	658		1,715,305	42	6
7	5	Utilities		26,780,136	317	0		1,715,305	0	7
8	6	Bldg Repairs & Maintenance		26,780,136	317	10		1,715,305	1	8
9	32	Interest		26,780,136	317	69,772		1,715,305	4,469	9
10	33	Real Estate Taxes		26,780,136	317	2,268		1,715,305	145	10
11	26	Insurance		26,780,136	317	140,925		1,715,305	9,026	11
12	27	Advertising & Promotions		26,780,136	317	(1,250)		1,715,305	(80)	12
13	25	Transportation		26,780,136	317	33,023		1,715,305	2,115	13
14	35	Car Rental		26,780,136	317	366		1,715,305	23	14
15	23	Conferences & Conventions		26,780,136	317	23,216		1,715,305	1,487	15
16	20	Subscriptions, Dues, Awards		26,780,136	317	436,809		1,715,305	27,978	16
17	21	Furniture & Fixtures		26,780,136	317	0		1,715,305	0	17
18	6	Machinery & Equipment		26,780,136	317	0		1,715,305	0	18
19	35	Equipment Rental		26,780,136	317	59,787		1,715,305	3,829	19
20	6	Equipment Repair & Maint		26,780,136	317	27,273		1,715,305	1,747	20
21	20	Employee Recruitment		26,780,136	317	(2,468)		1,715,305	(158)	21
22	7	Security & Waste Removal		26,780,136	317	11,939		1,715,305	765	22
23	21	All Other Miscellaneous		26,780,136	317	94,039		1,715,305	6,023	23
24	30	Depreciation		26,780,136	317	396,428		1,715,305	25,392	24
25	TOTALS					$ 5,700,288	$ 1,460,744		$ 365,110	25

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lutheran Social Services of Illinois
Street Address: 1001 E. Touhy Ave. Ste 50
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (847) 635-4600
Fax Number: (847) 635-6764

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Non Capital Direct Costs	43,482,296	253	$ 866,459	$ 866,459	4,598,519	$ 91,633	1
2	22	Empl Benefits & Taxes		43,482,296	253	155,209		4,598,519	16,414	2
3	19	Prof Fees & Contract		43,482,296	253	150,167		4,598,519	15,881	3
4	21	Supplies, Telephone		43,482,296	253	38,026		4,598,519	4,021	4
5		Postage, Out. Printing		43,482,296	253			4,598,519		5
6	34	Rental of Space		43,482,296	253	3,072		4,598,519	325	6
7	5	Utilities		43,482,296	253			4,598,519		7
8	6	Bldg Repairs & Maintenance		43,482,296	253	346		4,598,519	37	8
9	32	Interest		43,482,296	253			4,598,519		9
10	33	Real Estate Taxes		43,482,296	253			4,598,519		10
11	26	Insurance		43,482,296	253	673		4,598,519	71	11
12	27	Advertising & Promotions		43,482,296	253			4,598,519		12
13	25	Transportation		43,482,296	253	13,477		4,598,519	1,425	13
14	35	Car Rental		43,482,296	253	4,332		4,598,519	458	14
15	23	Conferences & Conventions		43,482,296	253	(1,109)		4,598,519	(117)	15
16	20	Subscriptions, Dues, Awards		43,482,296	253	21,258		4,598,519	2,248	16
17	21	Furniture & Fixtures		43,482,296	253			4,598,519		17
18	6	Machinery & Equipment		43,482,296	253			4,598,519		18
19	35	Equipment Rental		43,482,296	253	11,367		4,598,519	1,202	19
20	6	Equipment Repair & Maint		43,482,296	253	1,004		4,598,519	106	20
21	20	Employee Recruitment		43,482,296	253	40,053		4,598,519	4,236	21
22	7	Security & Waste Removal		43,482,296	253	157		4,598,519	17	22
23	21	All Other Miscellaneous		43,482,296	253	1,522		4,598,519	161	23
24	30	Depreciation		43,482,296	253	9,300		4,598,519	984	24
25	TOTALS					$ 1,315,313	$ 866,459		$ 139,102	25

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lutheran Social Services of Illinois
Street Address: 1001 E. Touhy Ave. Ste 50
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (847) 635-4600
Fax Number: (847) 635-6764

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Non Capital Direct Costs	4,177,314	2	$ 126,752	$ 126,752	1,715,305	$ 52,047	1
2	22	Empl Benefits & Taxes		4,177,314	2	42,177		1,715,305	17,319	2
3	19	Prof Fees & Contract		4,177,314	2	2,955		1,715,305	1,213	3
4	21	Supplies, Telephone		4,177,314	2	1,101		1,715,305	452	4
5		Postage, Out. Printing		4,177,314	2			1,715,305		5
6	34	Rental of Space		4,177,314	2	431		1,715,305	177	6
7	5	Utilities		4,177,314	2			1,715,305		7
8	6	Bldg Repairs & Maintenance		4,177,314	2			1,715,305		8
9	32	Interest		4,177,314	2			1,715,305		9
10	33	Real Estate Taxes		4,177,314	2			1,715,305		10
11	26	Insurance		4,177,314	2	218		1,715,305	90	11
12	27	Advertising & Promotions		4,177,314	2	1,747		1,715,305	717	12
13	25	Transportation		4,177,314	2	4,199		1,715,305	1,724	13
14	35	Car Rental		4,177,314	2			1,715,305		14
15	23	Conferences & Conventions		4,177,314	2	1,080		1,715,305	443	15
16	20	Subscriptions, Dues, Awards		4,177,314	2	293		1,715,305	120	16
17	21	Furniture & Fixtures		4,177,314	2			1,715,305		17
18	6	Machinery & Equipment		4,177,314	2			1,715,305		18
19	35	Equipment Rental		4,177,314	2			1,715,305		19
20	6	Equipment Repair & Maint		4,177,314	2			1,715,305		20
21	20	Employee Recruitment		4,177,314	2			1,715,305		21
22	7	Security & Waste Removal		4,177,314	2			1,715,305		22
23	21	All Other Miscellaneous		4,177,314	2	1,689		1,715,305	694	23
24	30	Depreciation		4,177,314	2	1,315		1,715,305	540	24
25	TOTALS					$ 183,957	$ 126,752		$ 75,536	25

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/02 Ending: 06/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Tax Exempt Bonds		X	Refinance Building Additions	N/A	9/23/93	$ 1,286,188	$ 2,783,518	08/15/20	0.0738	$ 210,026	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Mgmt Allocation		X	Management Allocation	N/A	N/A	N/A	N/A	N/A	N/A	4,469	6
7												7
8												8
9	TOTAL Facility Related						$ 1,286,188	$ 2,783,518			$ 214,495	9
	B. Non-Facility Related*											
10	Interest Income			Offset against Interest expense							(23)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (23)	14
15	TOTALS (line 9+line14)						$ 1,286,188	$ 2,783,518			$ 214,472	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/02 Ending: 06/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1998	8
	1999	9
	2000	10
	2001	11
	2002	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Matthew Center for Health COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0013896

CONTACT PERSON REGARDING THIS REPORT Sonia Channa

TELEPHONE (847) 390-1411 FAX #: (847) 635-6764

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A	N/A	$ N/A	$ N/A
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ N/A	$ N/A

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/02 Ending: 06/30/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 82,590 B. General Construction Type: Exterior Masonry Frame Steel Grids Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground
(such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	203,354	1958	$ 38,704	1
2					2
3	TOTALS	203,354		$ 38,704	3

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1959	1959	$ 444,500	$	40	$	$	$ 444,500	4
5			1966	1966	315,066	7,877	40	7,877		295,306	5
6	176		1976	1976	2,205,040	55,126	40	55,126		1,515,818	6
7			1976	1976	24,547	614	40	614		16,580	7
8			1977	1977	13,438	336	40	336		8,902	8
	Improvement Type**										
9	1983 Addition			1983	150,179		10			150,179	9
10	1978 Addition			1978	1,780		10			1,780	10
11	1979 Addition			1979	5,380		10			5,380	11
12	1983 Addition			1983	2,142		10			2,142	12
13	1984 Addition			1984	11,139		10			11,139	13
14	1985 Addition			1985	2,400		10			2,400	14
15	1986 Addition			1986	7,692		10			7,692	15
16	1987 Addition			1987	291,787	11,671	25	11,671		233,510	16
17	Renovations			1989	268,451		10			268,451	17
18	ADJUSTMENT PER IDPA - 1989 Renovations			1989	(22,714)		10			(22,714)	18
19	ADJUSTMENT PER IDPA - 1988 Costs			1988	14,914		10			14,914	19
20	Canopy / Western ave.			1992	30,720	1,228	25	1,228		14,138	20
21	Panasonic Camera System			1992	3,720		5			3,720	21
22	New Sidewalk			1992	2,500		10			2,500	22
23	Concrete Loading dock			1992	6,690		10			6,690	23
24	Bathroom Remodeling			1992	13,440	666	10	666		13,440	24
25	Chapel Renovation			1992	33,385	1,665	10	1,665		33,385	25
26	Generator & Mechanical Work			1993	43,564	4,356	10	4,356		41,510	26
27	New Roof West Building			1993	208,807	20,881	10	20,881		198,962	27
28	Generator Projct & electrical			1993	146,296	14,630	10	14,630		139,398	28
29	Upgrade West Building Electrical			1993	19,029	1,903	10	1,903		18,132	29
30	Alzeheimer Unit			1992	40,114	4,011	10	4,011		38,223	30
31	Alzeheimer Unit			1993	35,728	3,573	10	3,573		34,043	31
32	ADJUSTMENT PER IDPA - Alzeheimer Unit			1993	(6,025)		10	(602)	(602)	(6,025)	32
33	ADJUSTMENT PER IDPA - 1990 Improvements OHF			1990	19,450		10			19,450	33
34	Parking Lot Lighting			1994	17,300	1,730	10	1,730		16,483	34
35	Shower Room Renovation			1994	9,455	945	10	945		8,053	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Rehab Area Renovation	1994	$ 55,583	$ 5,558	10	$ 5,558	$	$ 47,343	37
38	Air Conditioning - West Bldg	1995	32,823	3,282	10	3,282		26,927	38
39	Air Conditioning Project - #95-056	1995	5,423	542	10	542		4,090	39
40	ADA Elevator Upgrade	1996	5,548	555	10	555		4,167	40
41	Air Conditioner - Laundry Room	1997	842	84	10	84		483	41
42	Fence & Installation	1997	674	67	10	67		387	42
43	Kitchen A/C & Installation	1997	17,500	1,750	10	1,750		13,132	43
44	Installation of Fire Doors	1997	4,897	196	25	196		1,093	44
45	Landscape Materials	1998	1,600	160	10	160		825	45
46	Retainers - Int. Design	1998	3,085	308	10	308		1,540	46
47	Interior Design Fees	1998	1,349	135	10	135		651	47
48	Interior Design Fees	1998	3,000	300	10	300		1,447	48
49	Construction Project	1998	11,282	1,128	10	1,128		5,253	49
50	Painting & Staining	1998	13,725	1,373	10	1,373		6,390	50
51	Painting & Staining	1998	13,723	1,372	10	1,372		6,389	51
52	HVAC/Electrical Upgrade	1998	6,482	648	10	648		2,965	52
53	1998 Addition	1998	170,700	6,828	25	6,828		33,542	53
54	Wall & Door Install - Décor	1999	2,850	285	10	285		1,233	54
55	Architecture, Electrical	1998	10,602	1,060	10	1,060		4,588	55
56	Window Replacement	1998	4,765	476	10	476		2,062	56
57	Energy Study & Admin	1998	1,948	195	10	195		843	57
58	HVAC & Admin	1998	3,325	332	10	332		1,439	58
59	Carpet Installation	1999	125,765	12,577	10	12,577		53,355	59
60	MDC Wallcovering	1998	4,400	440	10	440		1,867	60
61	Add-Ons for Lobby Window	1999	1,800	180	10	180		764	61
62	Install Wood Veener	1999	894	89	10	89		379	62
63	Paint Sprinkler Pipes	1999	120	12	10	12		51	63
64	Air Conditioning	1999	446	18	25	18		73	64
65	Glass repair - bldg décor project	1999	2,659	266	10	266		1,062	65
66	Remodel 6 resident rooms	1999	720	72	10	72		288	66
67	120L/F/Roppe & Johnson	1999	170	17	10	17		68	67
68	Installation of Awnings	1999	8,307	831	10	831		3,038	68
69	Couch Wallcovering	1999	61	6	10	6		21	69
70	TOTAL (lines 4 thru 69)		$ 4,876,983	$ 172,354		$ 171,752	$ (602)	$ 3,765,836	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,876,983	$ 172,354		$ 171,752	$ (602)	$ 3,765,836	1
2	Installation of Awnings	2000	241	24	10	24		82	2
3	Installation of new windows	2000	35,200	3,520	10	3,520		11,707	3
4	Electric Upgrade	2000	16,253	1,625	10	1,625		8,398	4
5	2000 Addition	2000	49,564	4,956	10	4,956		5,350	5
6	Door to laundry	2000	5,995	600	10	600		1,794	6
7	Furniture & Flooring	2001	341,679	34,168	10	34,168		102,224	7
8	Cable tv system	2001	15,169	1,517	10	1,517		4,538	8
9	Awning Installation	2001	235,000	23,500	10	23,500		70,308	9
10	Exahust Fans Replacement	2001	6,055	606	10	606		1,812	10
11	Air Conditioning Project	2001	88	4	25	4		11	11
12	Air Conditioning project	2001	107,325	4,293	25	4,293		12,857	12
13	Air Conditioning project	2001	253,678	10,147	25	10,147		30,389	13
14	Signs Internally V Shaped	2001	20,570	2,057	10	2,057		6,154	14
15	Air Conditioning project	2001	147,096	5,884	25	5,884		16,622	15
16	Installation of private Cable System	2001	15,170	1,517	10	1,517		4,281	16
17	Seal Coating- St	2001	5,150	206	25	206		582	17
18	Boiler Set Up	2001	214,651	8,586	25	8,586		15,690	18
19	Facility Upgrades	2001	1,509	151	10	151		414	19
20	Facility Upgrades	2001	774	77	10	77		212	20
21	St Matts Air Conditioning	2001	78,348	3,134	25	3,134		8,330	21
22	Windows & Screen Replacement	2001	1,683	168	10	168		433	22
23	Facility Upgrades Cable	2001	5,467	547	10	547		1,407	23
24	Air Conditioning Project	2001	4,715	189	25	189		470	24
25	Air Conditioning Project	2001	11,400	456	25	456		1,097	25
26	Garbage Disposers	2001	3,512	350	10	350		787	26
27	Install chilled water cooler	2001	103,301	4,132	25	4,132		8,583	27
28	Fix Door and Wall	2001	3,280	131	25	131		404	28
29	Update Fire Panel	2000	7,051	705	10	705		1,463	29
30	Valve Project	2001	3,370	134	25	134		269	30
31	Counter Tops	2001	43,338	4,334	10	4,334		8,267	31
32	Windows & Screen	2001	1,683	168	10	168		321	32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,615,298	$ 290,240		$ 289,638	$ (602)	$ 4,091,092	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,615,298	$ 290,240		$ 289,638	$ (602)	$ 4,091,092	1
2	Tree Removal	2001	2,550	255	10	255		401	2
3	Facility Upgrade	2002	37,600	3,760	10	3,760		5,279	3
4	Facility Upgrade	2002	75,200	7,520	10	7,520		75,200	4
5	Tuckpointing	2003	8,555	178	10	178		178	5
6	Masonry Restoration	2003	47,520	195	10	195		195	6
7	Parking Lot Improvements	2003	7,725	32	10	32		32	7
8	FY 89 IDPA Audit - Phone System Amplifiers	1989	491		5			491	8
9	FY 89 IDPA Audit - Garbage Disposer	1989	2,654		5			2,654	9
10	FY 89 IDPA Audit - Ceiling Fans	1989	2,724		7			2,724	10
11	FY 89 IDPA Audit - Toilet Frames	1989	734		5			734	11
12	FY 89 IDPA Audit - Air Conditioner	1989	993		5			993	12
13	Management Assets - Security System	1999	33,745		10	753	753	N/A	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,835,789	$ 302,180		$ 302,331	$ 151	$ 4,179,973	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 846,124	$ 75,486	$ 98,740	$ 23,254	Various	$ 335,313	71
72	Current Year Purchases	62,164	581	3,699	3,118	Various	581	72
73	Fully Depreciated Assets	308,781				Various	308,781	73
74								74
75	TOTALS	$ 1,217,069	$ 76,067	$ 102,439	$ 26,372		$ 644,675	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transp.	1997 Champion Challenger	1997	$ 54,610	$ 7,801	$ 7,801	$	7	$ 44,697	76
77										77
78										78
79										79
80	TOTALS			$ 54,610	$ 7,801	$ 7,801	$		$ 44,697	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,146,172	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 386,048	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 412,571	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 26,523	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,869,345	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	1990 Ford Paratransit Van	$ 36,850	$	$ 36,850	86
87	1997 Ford One	39,963	5,428	34,598	87
88	1988 Dodge Sweptline P.U.	10,040		10,040	88
89	Management Autos	1,417		N/A	89
90					90
91	TOTALS	$ 88,270	$ 5,428	$ 81,488	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/02 Ending: 06/30/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 23,181 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18	N/A				18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)	N/A			
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs	N/A						7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number St Matthew Center for Health # 0013896 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/03 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	N/A		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$	$	48

***(See instructions.)**

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ N/A	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)		7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$	24 *

Note:
Lutheran Social Services of Illinois is unable to provide meaninful comparative balance sheets or statements of changes in equity for individual programs due to the commingling of cash, other assets, and most liabilities in a complex, multi-funtional service agency. Any balance sheet prepared with only those assets, liabilities and fund balances identifiable with specific programs would not balance or ptresent a meaningful picture of that program's financial status.

*** This must agree with page 17, line 47.**

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,680,236	1
2	Discounts and Allowances for all Levels	(110,169)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,570,067	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,900	13
14	Non-Patient Meals	775	14
15	Telephone, Television and Radio	5,465	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 8,140	23
	D. Non-Operating Revenue		
24	Contributions	16,396	24
25	Interest and Other Investment Income***	23	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,419	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Cookie Sales	219	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 219	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,594,845	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,385,894	31
32	Health Care	3,515,415	32
33	General Administration	1,877,342	33
	B. Capital Expense		
34	Ownership	620,820	34
	C. Ancillary Expense		
35	Special Cost Centers	96,360	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,495,831	40
41	**Income before Income Taxes (line 30 minus line 40)****	99,014	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 99,014	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,767	1,941	$ 61,384	$ 31.62	1
2	Assistant Director of Nursing	13,391	14,503	158,036	10.90	2
3	Registered Nurses	44,184	49,463	1,030,273	20.83	3
4	Licensed Practical Nurses	39,556	44,892	546,739	12.18	4
5	Nurse Aides & Orderlies	70,516	76,709	816,102	10.64	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,620	1,845	21,305	11.55	8
9	Activity Director	1,884	2,064	36,735	17.80	9
10	Activity Assistants					10
11	Social Service Workers	4,303	4,702	71,622	15.23	11
12	Dietician					12
13	Food Service Supervisor	4,056	4,559	56,576	12.41	13
14	Head Cook	5,589	6,070	50,933	8.39	14
15	Cook Helpers/Assistants	23,101	24,961	187,104	7.50	15
16	Dishwashers					16
17	Maintenance Workers	8,125	9,036	135,839	15.03	17
18	Housekeepers	14,048	14,863	110,194	7.41	18
19	Laundry	4,940	5,736	51,281	8.94	19
20	Administrator	1,778	2,001	63,415	31.69	20
21	Assistant Administrator					21
22	Other Administrative	1,740	1,953	45,083	23.08	22
23	Office Manager					23
24	Clerical	11,526	12,845	179,130	13.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,741	6,301	65,388	10.38	31
32	Other Health Care(specify)					32
33	Other(specify)	1,550	1,894	41,814	22.08	33
34	TOTAL (lines 1 - 33)	259,415	286,338	$ 3,728,953 *	$ 13.02	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	As Needed	$ 92,115	1,3	35
36	Medical Director	As Needed	14,500	9,3	36
37	Medical Records Consultant	As Needed	4,128	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	As Needed	2,276	10,3	39
40	Physical Therapy Consultant	As Needed	215,763	10a,3	40
41	Occupational Therapy Consultant	As Needed	83,884	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	As Needed	16,179	10a,3	43
44	Activity Consultant	As Needed	4,777	10a,3	44
45	Social Service Consultant				45
46	Other(specify) See Attached	As Needed	27,477	Various	46
47	Legal & Audit Accounting	As Needed	17,155	19,3	47
48	Laundry Services	As Needed	69,300	4,3	48
49	TOTAL (lines 35 - 48)		$ 547,554		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gerrianne Dathe	Administrator	0	$ 63,415
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 63,415

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Joint Commission	Healthcare Survey	$ 0
Duane Morris & Heckscher	Legal Fees	130
Transwords System INC	Collection Services	2,025
Littler Mendelson, PC	Legal Fees	0
Anderson	Audit & Accountant	0
Frost Rutthenberg and Roth	Audit & Accountant	15,000
LSSI	Management Services	579,074
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 596,229

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 190,202
Unemployment Compensation Insurance	42,984
FICA Taxes	269,475
Employee Health Insurance	315,291
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
Pension	26,926
Other Benefits	1,795
Management Allocation Benefits	47,614
TOTAL (agree to Schedule V, line 22, col.8)	$ 894,287

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Advertising & Promotion, Awards, Grants	9,978
Subscriptions & Books	2,184
Membership Dues	5,538
Management Allocation	34,424
Less: Public Relations Expense	( )
Non-allowable advertising	(0)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 52,124

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Vehicle Operating Cost	(5)
Employee Milage Payment	2,200
Meals, Lodging	709
Seminar Expense	2,187
Conference & Convention	240
Prior Fiscal Year travel	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,331

**See instructions.

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6	N/A												
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/02 Ending: 06/30/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $ 5,308**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **54,320** Line **10 years**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **96,360**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **775**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Clifton Gunderson LLP** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **In Progress, will send as soon as avail**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.